STATES FACE MAJOR OBSTACLES

IN INTEGRATING FINANCING AND SERVICE DELIVERY

FOR PERSONS DUALLY ELIGIBLE

FOR MEDICARE AND MEDICAID

U.S. SENATE SPECIAL COMMITTEE ON AGING

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I. INTRODUCTION AND BACKGROUND

Mr. Chairman and members of the Special Committee on Aging, my name is Pamela Parker. I am director of the Minnesota Senior Health Options Demonstration at the Minnesota Department of Human Services. The Minnesota Department of Human Services administers the Medicaid program in the State of Minnesota. We provide health care coverage for over 550,000 families, children, adults and disabled and elderly persons, making us the largest single health care purchaser in the state. Since 1985 Minnesota has operated the Prepaid Medical Assistance Program (PMAP) under a statewide 1115 waiver which requires Medicaid recipients to enroll in their choice of managed care plans. The PMAP program has 182,000 enrollees in HMOs which includes about 40% of the state's 48,000 dually eligible seniors. Another 100,000 Minnesota Care enrollees are also served through HMOs. Minnesota Care is a state subsidized program funded in part though Medicaid. Minnesota is in the process of expanding managed care choices for public health care programs throughout the state.

In fact, enrollment in HMOs or other forms of managed care is the norm for much of Minnesota's population. The majority of employed persons with health care coverage in the State of Minnesota are enrolled in HMOs or some other form of managed care plan. About one third of all seniors in Minnesota have also chosen to enroll in Medicare managed care plans. Minnesota requires that all HMOs be non-profit. We have extensive licensing requirements and consumer protections, and surveys show seniors have a very high degree of satisfaction with HMO management of health care services in Minnesota.

Minnesota has required enrollment of dually eligible seniors in its Prepaid Medical Assistance Program

since it began in 1985. PMAP covers Medicare coinsurance and deductibles, prescription drugs and other Medicaid services for dual eligibles, but does not include long term care services which are paid fee for service. However, since 1990 the State has been working on a model to integrate Medicare and Medicaid and acute and long term care financing and services for dual eligibles in order to resolve the administrative conflicts and reduce cost shifting between the two programs. Conflicts between the programs result in poor clinical care incentives and a confusing, fragmented system for seniors. These problems must be resolved because Medicare reforms are certain to result in increased costs for dual eligibles that states will be unable to absorb, especially if proposed caps on Medicaid are enacted.

MINNESOTA SENIOR HEALTH OPTIONS DEMONSTRATION

In 1995 Minnesota was the first state to receive approval from HCFA to demonstrate a new program which integrates Medicare and Medicaid funding and acute and long term care service delivery in order to better serve seniors dually eligible for both Medicare and Medicaid in the seven county metro area in Minnesota. The demonstration operates under a combination of Medicaid 1115 and Medicare 222 waivers and is supported by grants from the Robert Wood Johnson Foundation.

This new Minnesota Senior Health Options (MSHO) demonstration was implemented in March 1997 and is now enrolling and serving a full range of dually eligible seniors including those in nursing homes. While dually eligible seniors in Minnesota are required to enroll in managed care plans under the PMAP program, enrollment in MSHO is voluntary. MSHO is another product choice given to seniors in the metro area as they enroll in the PMAP program.

The demonstration operates through contracts with HMOs who in turn provide all Medicare and Medicaid services including home and community based services and nursing home care. A unique feature of the demonstration is that all services are covered under one contract with each plan and the contract is managed by the State. Under the demonstration the State is allowed to contract with smaller Medicaid plans who have not been able to participate in Medicare risk because they do not meet the requirement for 50% commercial enrollment. (These plans must meet most other requirements for Medicare risk contractors). However, Medicare risk plans may also participate. Other demonstration features include a single enrollment date and process for both Medicare and Medicaid and combined Medicare and Medicaid rate structures, grievance procedures and quality assurance and oversight processes and a risk adjustment payment from Medicare for frail elderly maintained in the community instead of nursing homes.

We think this program has great potential to:

rearrange fiscal incentives to support sound clinical care,

simplify a badly fragmented "non-system" of care for seniors and providers, and to

increase accountability for costs, quality and outcomes of care.

Interest in this program has been high and we have received hundreds of calls from policy makers, providers, consumer advocates and researchers across the country.

Minnesota spent almost six years trying to develop the Minnesota Senior Health Options program. We faced fundamental obstacles which had to be worked through in extraordinary detail with HCFA's Office of Research and Demonstrations. I have attached a more complete description of Minnesota's MSHO program to this testimony for those who are interested. Rather than taking time today to describe

the details of our program I have tried to outline and provide further discussion of the fundamental policy issues many states are facing as they try to develop integrated managed care systems for dual eligibles.

II. STATES LACK CONTROL OVER DUAL ELIGIBLE COSTS AND SERVICE DELIVERY BECAUSE MEDICARE POLICY DRIVES UTILIZATION OF MEDICAID SERVICES FOR DUAL ELIGIBLES

People who are dually eligible for Medicare and Medicaid comprise only about 18% of Minnesota's Medicaid enrollees but they account for as much as 50% of Minnesota's Medicaid costs. 60% of Minnesota's dually eligible seniors reside in nursing homes and Medicaid is the largest payor of their health care costs. States must be able to manage costs for dual eligibles if they are to control overall growth in the Medicaid budget, especially if per capita caps on Medicaid are enacted by Congress. However, states lack the tools to manage costs for dual eligibles because Medicare policy has such a large effect on Medicaid utilization and spending.

Medicaid usually covers prescription drugs, transportation and long term care services while Medicare covers physician, hospital and related acute care costs for this population. In addition, Medicaid acts as a kind of Medigap policy for dual eligibles, paying for the Part B premium and coinsurance and deductibles not covered by Medicare. Physicians must authorize Medicaid services but they are paid mostly by Medicare and may be operating according to Medicare payment incentives.

Since states have no control over Medicare provider payment policies, states have limited ability to influence medical practice patterns which lead to increased utilization of Medicaid services for dual eligibles. For instance, Medicare pays physicians more to see beneficiaries in clinics and hospitals, less for nursing home visits and nothing for working with families to keep seniors out of nursing homes. This payment structure results in higher medical transportation costs and more permanent nursing home placements paid by Medicaid. Medicare pays hospitals under the DRG system with Medicaid picking up the Part A deductibles for dual eligibles. But hospitals may have incentives to discharge dual eligibles to nursing homes paid largely under Medicaid.

Changes in either program may shift costs to the other since many Medicare and Medicaid benefits overlap and substitute for each other. Millions are spent in administrative procedures designed to fight over which program should pay what under what circumstances. Providers must bill two or three different places for parts of the same service. These conflicts increase costs for both programs and produce fragmentation of care and poor clinical care incentives.

States are reluctant to participate in cost savings strategies for Medicare because they fear that Medicare policy changes will result in higher Medicaid costs. States have no way of accessing any of the Medicare savings to help cover their increased liabilities. Furthermore, if Medicare reforms such as co-payments for home health visits are enacted along with per capita caps on Medicaid, states won't be able to absorb these cost increases for dual eligibles.

III. ENROLLMENT IN MEDICAID MANAGED CARE PLANS FOR DUAL ELIGIBLES CAN START TO ADDRESS A FRAGMENTED SYSTEM BUT HCFA'S MEDICARE POLICY IS A BARRIER

States are increasingly relying on managed care purchasing strategies for all but their most costly populations, seniors and disabled persons. Enrollment of seniors in state Medicaid managed care plans has been minimal because of conflicts with Medicare policy. A few states have introduced voluntary

managed care programs which include dual eligibles but enrollment has been relatively small. States fear they will not be able to control costs without broader enrollment. However, there are severe limitations on the ability of states to require enrollment of dual eligibles in managed care programs.

NEW HCFA POLICY SEVERELY LIMITS ENROLLMENT OF DUAL ELIGIBLES IN NEW MEDICAID MANAGED CARE PROGRAMS

HCFA has recently taken the position that enrollment of dual eligibles in mandatory Medicaid managed care programs is allowable only if this enrollment does not restrict Medicare services in any way. This means that the Medicaid plan cannot require the dual eligible enrollee to stay within their network of physicians, skilled nursing facilities, hospitals or home care providers because these services are usually covered by Medicare. Since physicians also control utilization of Medicaid services such as prescription drugs and long term care services for which the Medicaid plan is liable, this policy leaves the managed care plan without its primary means of managing utilization and makes managed care enrollment almost meaningless. It places the plan at financial risk for services over which they have no means of control.

THESE LIMITATIONS INCREASE FRAGMENTATION OF CARE FOR DUAL ELIGIBLES

Worse yet, this arrangement virtually guarantees fragmentation and lack of communication between care providers as the Medicaid health plan has no way of knowing what physician or health provider may be authorizing or providing services. It increases denials and delays in obtaining Medicaid services such as prescription drugs, transportation and medical supplies because physicians ordering them may not be aware of the plan's formularies and other payment and prior authorization policies.

At issue specifically is how payments of the Medicare coinsurance and deductibles for which Medicaid is responsible are handled in these arrangements. Some states, like Tennessee, which mandates enrollment of dual eligibles in Medicaid managed care plans, have been required to pay the Medicare coinsurance and deductibles outside of the Medicaid plan. For instance, dual eligibles may see a physician inside or outside the plan network, but either way the plan does not have the ability to pay the physician for any of their services. The physician bills Medicare directly and the coinsurance is paid directly by the State. In this approach, enrollees do not choose a primary care clinic so there is no primary physician case management and the system remains essentially fee for service except for a few services like prescription drugs. According to both state and health plan officials this arrangement creates huge problems.

Utah, which also requires enrollment of dual eligibles in Medicaid managed care in some parts of the State, has been allowed to include the coinsurances and deductibles in the health plan's capitation rate, making the plan responsible for paying any out of network providers. In this method the plan can educate the enrollee to make a primary care clinic choice, and the plan does pay the physician the coinsurance for their visits, but they also must bear the risk of payment for the coinsurance if the enrollee goes out of network. It is doubtful that this arrangement can be widely used by states. Many health plans say they would not be willing to go at risk for payment of coinsurances and other Medicaid services ordered by out of plan physicians.

ENROLLMENT OF DUAL ELIGIBLES IN STATES WITH EXCEPTIONS TO THE NEW POLICY WORKS WELL

Three states, Minnesota, Arizona and Oregon, have long standing approval from HCFA for mandatory enrollment of dual eligibles where the enrollee is required to stay within the Medicaid plan network in order to have the Medicare coinsurance paid to the provider. All of these states have fairly large networks of providers so there is a wide choice of participating physicians from which to choose. Similar to a Point of Service (POS) plan, dual eligibles can go to providers outside the Medicaid network if they pay some costs out of pocket. Enrollees can still go out of network for Medicare services but they will be billed for the Medicare coinsurance and deductibles. The arrangement has worked well in these states. Minnesota has been operating this way under the PMAP program since 1985 without problems. Arizona is the only state which has also included all long term care costs under these managed care arrangements. The requirement for enrollment and control of coinsurance and deductibles have been key elements of making that program work financially. Many other states are interested in Arizona's success because they see managed care as a tool to assist in managing long term care costs.

However, HCFA has said that they will not approve any more of these arrangements because they may infringe on Medicare freedom of choice.

HCFA'S POLICY IGNORES TRADEOFFS MOST MEDICARE BENEFICIARIES MUST MAKE BETWEEN BROADER CHOICES AND LOWER COSTS FOR SUPPLEMENTAL COVERAGE

This new policy interpretation calls into question the very nature of the difference between the Medicare and Medicaid programs. Medicare covers a universal group of seniors without regard to income and assets. Yet, Medicare is not designed to cover all health care needs for seniors and in fact most seniors must purchase some kind of Medigap policy or Medicare plan coverage in order to cover the coinsurance and deductibles and other costs not covered through Medicare. While there are basic national standards for those Medigap and Medicare plan policies, they include certain rules and parameters for the extent of coverage and the beneficiary and providers must follow them in order to receive payment. Often this involves smaller network choices in return for lower out of pocket or premium payments.

Medicaid covers only those who do not have enough income or resources to cover their health care needs. For dual eligibles, Medicaid acts as their Medigap or Medicare plan policy, covering the coinsurances and deductibles and providing extended coverage when Medicare coverage runs out. The State as insurer and administrator of this coverage sets certain rules for coverage just as the Medigap or Medicare plans do. Low income seniors elect to enroll in Medicaid to receive this coverage. In return for complying with Medicaid's rules, the dual eligible receives complete coverage for a broad set of benefits and costs they cannot afford on their own. Because the coverage they receive includes long term care benefits, dual eligibles have even more comprehensive coverage than most seniors who pay for private insurance coverage. HCFA's new policy ignores the fact that most Medicare beneficiaries make certain trade offs between freedom of choice and costs of health care when they obtain Medigap type coverage and that by enrolling in Medicaid the dual eligible is making a similar trade off.

HCFA'S POLICY LIMITS STATE'S ABILITY TO MANAGE THEIR LONG TERM CARE RISK

As mentioned above, Medicaid covers services far beyond those covered in most Medigap policies or Medicare plans, such as long term care. The problem with HCFA's policy is keenly illustrated in the

example of skilled nursing facility (SNF) coverage. Medicare beneficiaries may receive up to 100 days of SNF care if certain criteria are met. When stays for dual eligibles do not meet those criteria, Medicaid covers the costs as NF (Nursing Facility) custodial stay. Medicare pays the first 20 SNF days without a coinsurance, but days 21-100 require a coinsurance of $95 per day. For dual eligibles, Medicaid picks up this cost. In Minnesota, the Medicare coinsurance amount is about the same as the average Medicaid NF rate. Therefore after the first 20 SNF days the distinction between what day is a Medicare SNF day and what day is a Medicaid NF day is quite meaningless as the State is paying almost half of this cost out of state tax dollars either way. Minnesota's costs for this Medicare SNF coinsurance runs about $1,000,000 a month and we are a state that tends to have a low SNF utilization rate. This is a significant Medicaid expense. Yet, HCFA's policy would greatly restrict the State's ability to manage these costs because days 21-100 are considered Medicare coinsurance days.

Because of the overlap and substitution between Medicare and Medicaid benefits and the lack of distinctions between acute and long term care services, Medicaid is at great risk of cost shifting from Medicare providers. HCFA's policy essentially forces the State to take all the risk for long term care without means of protection. This policy must be revised to allow states to manage all of their costs including coinsurances and deductibles through enrollment in managed care plans.

IV. POOLING MEDICARE AND MEDICAID FINANCING CAN ADDRESS MANY PROBLEMS FOR DUAL ELIGIBLES

While current HCFA policy appears to preclude additional effective mandatory managed care models for dual eligibles, many states continue to explore voluntary managed care demonstrations which have the potential of integrating Medicaid and Medicare and acute and long term care services for dual eligibles.

Pooling Medicare and Medicaid funding through integrated managed care delivery systems can provide the flexibility needed to reduce conflicts between the two programs. Pooled financing allows managed care entities and long term care providers to develop collaborative clinical delivery structures and re-arrange payment strategies to improve quality and accountability for services to dual eligibles. Once these financing barriers are eliminated, managed care organizations have the opportunity to coordinate care management across the full range of acute and long term care services and address the clinical conflicts described above. Medicaid and Medicare are both protected from cost shifting since one entity is responsible for the full range of services.

These strategies are essential to successful operation under any future Medicaid spending caps. Even if Medicaid caps are not enacted, states must develop more effective systems for managing costs and services for dual eligibles as the population ages and the baby boomers near retirement. Demographic trends will place immense pressures on already strapped state resources and states cannot afford to wait to begin development of more efficient care delivery systems to meet the projected increases in need. States must be given the authority to pursue these strategies before it is too late to gain experience with models that are effective.

V. STATES FACE MAJOR POLICY ISSUES IN INTEGRATING MEDICARE AND MEDICAID SERVICE DELIVERY AND FINANCING FOR DUAL ELIGIBLES

MOST CURRENT DEMONSTRATIONS ARE TOO LIMITED TO MEET STATE NEEDS

Demonstrations like PACE and SHMO and those advocated by the National Chronic Care Consortium (NCCC) provide successful clinical models from which to build. However, current PACE and SHMO demonstrations are of limited assistance to states because sites are limited and enrollment capacity is small and may be targeted only to a subset of the dual eligible population. The role of states in design and management of these demonstrations has been quite minimal even though states remain a primary payor of services. Therefore many states are seeking broader statewide purchasing strategies which build on the NCCC principles and the experience in PACE and SHMO demonstrations but have the capacity to serve larger numbers of dual eligibles with varied needs.

BROADER OPTIONS FOR MERGING MEDICARE AND MEDICAID FINANCING INVOLVE COMPLEX ADMINISTRATIVE AND POLICY ISSUES

In addition to the PACE and SHMO models there appear to be two other approaches under current HCFA authority through which states can pursue these demonstrations. One is to "piggy back" Medicaid managed care contracts operated under Medicaid 1115 or 1915(b) waivers onto Medicare managed care plans and to encourage separate enrollment in both products under one plan. A newer approach is to couple Medicaid 1115 with Medicare 222 waivers to merge Medicare and Medicaid contracting and payment requirements. This is the approach taken by Minnesota, however, HCFA has expressed reluctance to approve more of these arrangements. Some of the complex policy and administrative issues involved in each of these approaches are described below.

OPTION ONE: ENROLLMENT OF DUAL ELIGIBLES IN MEDICARE MANAGED CARE PLANS

Like other Medicare beneficiaries, dual eligibles may choose to enroll in Medicare managed care plans. This enrollment poses both opportunities and great problems for states in trying to coordinate benefits for this population as discussed below.

Opportunities In Enrollment of Dual Eligibles in Medicare Managed Care Plans

1. Cost Savings and Clarification of Freedom of Choice

Where Medicare risk payments (AAPCCs or Average Adjusted Per Capita Costs) are high and therefore monthly premiums are low or have been reduced to 0, low income seniors, including dual eligibles may be enrolling in Medicare risk plans in larger numbers. Often these plans provide extra benefits such as prescription drugs which then overlap Medicaid benefits. State Medicaid agencies may benefit from cost savings created by these extra benefits if they can figure out how to avoid duplicative payments for these overlapping benefits.

Some states are "piggy backing" Medicaid managed care contracts onto Medicare risk plans so that enrollees can receive both Medicare and Medicaid services through a more coordinated system. These arrangements can solve many of the freedom of choice and network problems discussed above. However, there are also many problems with increased enrollment of dual eligibles in Medicare managed care plans as discussed below.

Problems With Enrollment of Dual Eligibles in Medicare Managed Care Plans

1. Lack of Data Sharing About Enrollment

There is no automatic system of communication between the plans and the States or HCFA and the states to identify dual eligibles who are enrolled in these plans. A few states have obtained permission to process data from HCFA to obtain this information but the approval for getting the data and the subsequent process of matching the data are extremely cumbersome.

2. Difficulties in Avoiding Duplicate Payment for Overlapping Benefits

Where there are many Medicare risk plans, they may all have sightly different benefit sets, and plans may be constantly changing their benefit sets in response to a competitive market. This makes it very difficult to track and avoid duplicate Medicaid payments for overlapping benefits. In addition, financial documents submitted to HCFA (Adjusted Community Ratings) which outline details of how costs and benefits were calculated are private and states may not have access to them.

3. Unstable Markets and Medicare Managed Care Plans May Not Want to Contract with Medicaid

Medicare managed care plans may not want to contract with Medicaid and there is nothing requiring them to do so. So it is up to the State to attempt to negotiate with each separate plan. In some areas, the Medicare plan market is highly volatile and plans go in and out of the market leaving Medicaid trying to piggy back its Medicaid contracts on a very unstable base.

4. Enrollment in Two Different Plans

Medicare and Medicaid may not contract with the same plans since Medicare and Medicaid plan requirements are different. Many Medicare managed care plans do not have contracts with Medicaid and Medicaid managed care plans may not meet requirements for Medicare risk contracts with HCFA (eg. the requirement for 50% commercial enrollment). In areas where dual eligibles may also be enrolled in Medicaid managed care, they may end up in two different plans which causes huge difficulties in coordination of benefits. Because of the lack of systematic information, states and plans may not even know of this conflicting enrollment until providers try to bill and services or payments are denied.

5. Conflicting and Duplicative Administrative Requirements

States who try to piggy back Medicaid contracts on Medicare managed care contracts also face problems with conflicting and duplicative administrative requirements. HCFA contracts directly with Medicare HMOs while the States choose and manage Medicaid managed care plan contracts. Federal regulations and administrative requirements for enrollment and dis-enrollment, marketing, grievance procedures, payment schedules, oversight, data collection and virtually everything else involved in administration differs between Medicare and Medicaid. This makes it terribly difficult for the plan to operate in an efficient manner. It is subject to two different contracts with two different managing entities and two different sets of requirements for the same dually eligible enrollees.

6. Confusing Marketing Materials and Consumer Information

Furthermore, information approved under Medicare for distribution to enrollees may be misleading when applied to dual eligibles. Since HCFA reviews Medicare materials and the State reviews Medicaid materials under very different sets of rules, there is no easy way to coordinate this information to assure that it makes sense to the dually eligible beneficiary. A few states have worked out intricate arrangements with HCFA Regional Offices to try to coordinate but there remain many problems with those arrangements.

7. Medicare Managed Care Payments May Encourage Institutionalization

In addition, Medicare managed care payment policies may encourage cost shifting to Medicaid nursing home care for dual eligibles. Medicare payments are highest for persons in nursing homes. Since the Medicare risk plans are not liable for Medicaid long term care costs they have little incentive to avoid nursing home placements. Once persons are discharged to the community the AAPCC payment is considerably reduced and there are no risk adjustors targeted to the frail elderly to keep them out of nursing homes outside of special demonstrations. This is an example of where the acute care incentives work directly against Medicaid's desire to avoid premature institutional placement.

Some innovative Medicare managed care plans are interested enrolling stable chronically ill nursing home residents many of whom are dually eligible, because Medicare payments for them are high and they feel they can manage their acute care costs and avoid hospital stays more easily because they reside in a setting with 24 hour nursing coverage. Despite their many benefits, these plans also have the potential to shift costs to Medicaid in the form of higher nursing home per diems and higher nursing home utilization. This arrangement falls short of an integrated acute and long term care delivery system because plans are not liable for long term care costs.

8. Lack of Medicare Managed Care Plan Coverage Due to AAPCC Variations

Even if states are able to contract with Medicare risk plans many of those plans operate only in certain regions of the State due to county by county variations in the AAPCC. For instance in Minnesota, where most counties are far below the national average AAPCC payments, Medicare risk contractors operate only in the seven county metro area. The other 80 counties including all of our rural areas are denied the choice of a Medicare managed care plan. In some states, because of the AAPCC disparities, there are no Medicare managed care plans in operation at all.

9. Medicare Plans May Not Want to Take Risk for Medicaid LTC Costs

States who want to move to integrated models such as those illustrated by PACE, would want to include costs for Medicaid nursing home per diems and home and community based services in Medicaid managed care contracts with Medicare managed care plans. Including these costs in the plan's responsibility can be helpful in avoiding premature nursing home placements and encouraging the use of home and community based services. However, there are only a few isolated cases outside of the PACE and SHMO demonstrations where states have been successful in including nursing home per diem and home and community based services in managed care capitations. Only Arizona has been successful in implementing this as a state wide strategy. One reason they have been able to do this is that they are the only state which has approval to require enrollment in plans which include all long term care costs. In Minnesota's MSHO demonstration, it has been difficult to get providers to accept risk for nursing home costs and for home and community services for frail seniors residing in the community, despite Medicare risk adjustors from HCFA to alleviate this problem.

10. Many Medicare Plans Lack Experience With Long Term Care Services

Traditional Medicare plans may lack the special expertise needed to deal appropriately and successfully with special needs of dual eligibles. In most markets Medicare plans have not had reason to develop relationships with long term care providers, particularly those offering home and community based services. While some care management models now exist for long term nursing home residents as described above, there are few models for the frail elderly in the community outside of those developed

in PACE and SHMO.

OPTION TWO: STATE DUAL ELIGIBLE DEMONSTRATIONS UNDER MEDICAID 1115 AND MEDICARE 222 WAIVERS

Despite the great potential for piggy backing Medicaid contracts on Medicare risk plans there are still states where no such plans exist. Even where there is a Medicare risk market, those plans may not want to contract with the State for services to dual eligibles or the State may not want to contract with them for various reasons. The State may have Medicaid plans that are far more experienced with dual eligibles or provider networks more capable of becoming geriatric care networks who cannot meet the 50/50 requirement but are able to operate similar to PSOs. States in these circumstances that want to develop of integrated managed care systems for dual eligibles must look for other approaches. Combining Medicaid 1115 managed care and Medicare 222 payment demonstration waivers may be an option for some of these states.

So far Minnesota appears to be the only state granted the combination of Medicaid 1115 waivers and Medicare 222 waivers. While HCFA has expressed reluctance to consider more "Minnesota Style" waiver requests it is unclear whether this is because of some specific features of Minnesota's design or whether this applies to the 1115/222 combination in general. Regardless, a number of other states are pursuing similar waiver requests with HCFA and the Robert Wood Johnson Foundation has announced a new funding initiative to encourage more states to seek integrated models.

Advantages to Demonstrations Combining Medicaid 1115 and Medicare 222 Waivers

This combination of waivers was important to Minnesota because it allowed us to consolidate all the Medicare and Medicaid managed care requirements into one contract managed by one entity at the state level, alleviating many of the duplications and conflicts listed above in the "piggy backing" approach. Enrollment and enrollee education materials are written specifically for dual eligibles and are much clearer than two separate packages of conflicting materials. Enrollment for Medicare and Medicaid is simultaneous, leaving no questions about who is to cover what when. It also allowed the State to contract with Medicaid only plans which was important given the lack of Medicare plans in Minnesota. And there is one coordinated rate scheme which attempts to encourage home and community based services and align acute and long term care clinical incentives.

Disadvantages: Budget Neutrality Cap Methodology is Inappropriate for Voluntary Enrollment Model

A major drawback to these demonstrations is OMB's particular application of budget neutrality caps on the covered population. OMB has required that a per capita spending cap be set on the demonstration enrollees. OMB's method for developing such caps is based on experience with state wide 1115 waivers which are expanding eligibility for Medicaid. In Minnesota, the new MSHO demonstration did not attempt to increase eligibility. Costs cannot exceed pre-set HCFA approved rates times the number of people enrolled. The only costs that can vary is related to the "mix" of needs of individuals who enroll. However, since HCFA requires that enrollment in the demonstration be voluntary, it was impossible to predict what mix of dual eligibles would choose to enroll. If such a cap is set on the average dual eligible costs and the demonstration attracts a disproportionate share of high cost enrollees (for instance nursing home residents), the budget cap may be exceeded. The problem then becomes how to agree to an appropriate mix of enrollees on which to establish the cap.

Because of this problem Minnesota was forced to accept a cap on the entire potential population of

enrollees, putting the State at risk for expenditures into the future even for those not enrolled in the demonstration. If many of these dual eligibles enrolled in Medicare managed care plans where there may be incentives to shift costs to Medicaid, the State has no control over this choice and could be at risk for expenditures over the cap even though there is nothing they could have done about controlling those costs. This places any state who wants to proceed with such demonstrations in a "catch 22" position. A more reasonable budget neutrality method must be developed before states can move forward with dual eligible demonstrations under combined 1115/222 waivers.

VI. ADDITIONAL POLICY RECOMMENDATIONS

CONGRESS SHOULD ENCOURAGE HCFA TO REDUCE BARRIERS TO ENROLLMENT OF DUAL ELIGIBLES IN MEDICAID MANAGED CARE

Current HCFA policy should be changed to allow states to restrict payment of the Medicare coinsurance to Medicaid plan networks as long as those networks have adequate choices of physicians and other providers, similar to the arrangements in Minnesota's PMAP program, Arizona and Oregon. Without this change states cannot manage costs including those for long term care for dual eligibles and consumers will face an even more fragmented and uncoordinated system of care.

CONGRESS SHOULD ENCOURAGE HCFA TO ALLOW MORE 1115/222 DEMONSTRATIONS

While there may be some circumstances unique to Minnesota that led to certain waiver provisions that HCFA does not want to replicate, it is important that other states have the opportunity to pursue similar approaches. Congress should encourage HCFA to work with states who demonstrate the capacity to manage such coordinated programs for dual eligibles. In fact, very soon these approaches must move away from research and demonstration project status and become permanent features of the Medicaid and Medicare programs. States like Arizona prove that long term care can be effectively administered under a managed care system and models like PACE and SHMO and Minnesota's MSHO demonstration show that it is possible to merge Medicare and Medicaid financing. However, as discussed above, a fairer budget neutrality formula must be addressed before states can move forward.

Though it may seem premature to incorporate integrated financing models for dual eligibles into Medicare and Medicaid now, in a few years demographics are going to force this issue for us. We already know that the current fee for service system is fraught with problems. Use of managed care techniques can actually increase accountability in a system where accountability is fragmented and difficult to pinpoint. We should begin now to incorporate the tools we know will be needed for the future into the Medicare and Medicaid programs so that these approaches mature before the demographic crisis overwhelms our resources.

MORE ATTENTION MUST BE PAID TO QUALITY ASSURANCE (QA) MEASURES FOR CHRONIC CARE POPULATIONS

Minnesota's managed care licensing and consumer protection standards match or exceed all federal standards for Medicare risk contractors. However, many states lack strong oversight mechanisms. In general, current QA requirements and oversight procedures for both Medicare and Medicaid may be

inadequate to protect dual eligibles when profit incentives have the potential to overshadow the benefits managed care can bring to this population. As states step up efforts to enroll dual eligibles in various managed care arrangements, far more resources must be invested in adapting oversight and monitoring systems for Medicare and Medicaid managed care to address the needs of a more vulnerable population.

While the application of HEDIS measures to Medicare and Medicaid plans and requirements for Medicaid encounter data are steps forward, they barely begin to address the complex issues in outcome measurement for frail elderly and disabled. HEDIS measures do not really address a population which largely resides in a nursing home. For example the Health of Seniors measure uses the SF 36 assessment instrument to assess changes in function over time but it is not relevant to nursing home residents. The planned methodology for administration of the CAHPS satisfaction survey (telephone interviews) is not appropriate for obtaining accurate information from nursing home residents either though we understand that HCFA may be working to resolve this issue.

HCFA is placing much effort on methods of assuring provider quality in specific settings (e.g. the OASIS assessment instrument for persons served by certified home care agencies and the MDS assessment in nursing homes) but these approaches may perpetuate fragmented "silo-based" care where each provider is regulated as if they were operating individually rather than as one of many who may be involved in the care of a frail individual throughout that individual's course of care or treatment. These site based approaches give us only snapshots of an individual's care in a given setting rather than an understanding of how care has been provided and managed overall. Providers will continue to operate in a fragmented system where no locus of accountability for integrated care can be identified unless more emphasis in placed on the links between providers. It is not clear how these efforts will relate to new measurement approaches for managed care such as HEDIS but this is an area that should be explored.

If we are truly concerned about fragmentation of care and duplicative or uncoordinated provider efforts, it may be more important to begin to assess how care for dual eligibles is coordinated between settings of care, and to develop instruments to monitor what happens to care outcomes and patient satisfaction over time as they are served by different parts of the system. The National Chronic Care Consortium (with which the State of Minnesota has a contract to assist with integration of clinical care for MSHO plans), has developed a tool for assessing how well different parts of the system are working together. This kind of tool can be the basis for development of new methods to monitor care outcomes of individuals over time and across settings.

INCREASED RESOURCES FOR OMBUDSMAN AND CONSUMER EDUCATION ARE NEEDED

Even if states are not allowed to step up efforts to enroll dual eligibles in Medicaid managed care plans, enrollment of dual eligibles is likely to increase rapidly in Medicare managed care plans. Many traditional consumer advocate groups such as those working with nursing home residents are unprepared to deal effectively with managed care plans and lack the resources to cope with the new rules of the game they are encountering. Many more resources need to be invested in strong consumer advocacy and consumer education programs targeted directly to the most frail dual eligible groups such as nursing home residents.

It appears inevitable that capitated payment approaches are to be important tools for managing care and services for dual eligibles in the future just as they are for other parts of the Medicare population. While I believe strongly that it is possible to maintain and even improve quality and accountability of care and services in capitated financing arrangements, responsible policy makers and state Medicaid managers

never ignore the down side of capitation. Lack of strong consumer protections, poorly informed advocates and enrollees and inattentive oversight can doom state managed care programs for dual eligibles to failure. Funding to strengthen these functions is necessary to assure the credibility of the system in the long run.

HCFA SHOULD PURSUE SYSTEM WIDE SOLUTIONS TO CONFLICTS BETWEEN MEDICARE AND MEDICAID MANAGED CARE

Despite the problems outlined above, many states really have no choice but to seek better ways to coordinate Medicaid services with Medicare plans because this enrollment is growing and the problems with coordinating benefits for dual eligibles are immediate. HCFA too appears more open to creative solutions to the administrative and enrollment conflicts for dual eligibles and has even created new initiatives around dual eligible issues, but much more needs to be done and HCFA's resources in this area seem to be minimal. HCFA's Medicare policies for administration of Medicare risk plans still do not take into account the special issues around dual eligibles. Many of these problems could be solved by systematic solutions involving coordination of Medicare and Medicaid policy at the HCFA level and by building some policies to address issues for dual eligibles into Medicare's administration of managed care plans. This would be far more efficient than the plan by plan, state by state, region by region solutions being pursued now.

AAPCC REFORM IS NEEDED TO EXPAND CHOICES IN RURAL AREAS AND BRING MORE EQUITY TO BENEFIT PACKAGES AMONG STATES

AAPCC reforms such as those proposed by Senator Grassley and Representative Ramstad are essential to state efforts to increase coverage options for all seniors and are especially needed to increase the potential for integrated acute and long term care delivery systems for dual eligibles in rural areas. In Minnesota, Medicare plans are reluctant to operate outside of Minneapolis/St.Paul metropolitan area due to extremely low Medicare payments. This means the State is unable to expand its MHSO program beyond the metro area and dual eligibles in the rural areas are denied this option. AAPCC changes are needed before we can attract sufficient provider networks to maintain access in those areas.

Medicare plans in Minnesota offer few extra benefits and premiums are relatively high. Yet, in other states where AAPCCS are high plans are able to offer O premiums and many extra benefits. Many of these extra benefits (e.g.prescription drugs) are also part of the Medicaid benefit package. Some states may be able to realize considerable cost savings for the Medicaid budget by encouraging enrollment of dual eligibles in these plans. However, because of the disparities in the AAPCC formula, other states, like Minnesota, do not have the same advantages. This issue needs to be considered as part of any discussion of per capita caps on Medicaid and Medicare reform efforts must account for any disparate effects on state Medicaid budgets.

VII. CONCLUSION AND SUMMARY: CONGRESS SHOULD ASSURE STATES THAT THEY WILL HAVE THE TOOLS TO MANAGE THE CARE AND SERVICES FOR THE DUALLY ELIGIBLE POPULATION

States and HCFA can and must do a better job of managing care and services for the dually eligible than the current fragmented system which encourages cost shifting between providers and lacks accountability for care outcomes.

1. Current HCFA policy must be changed to allow states the ability to manage all of their costs including Medicare coinsurance and deductibles for dual eligibles through required enrollment in

Medicaid managed care plans. Under current HCFA policy, care and services for dual eligibles will become even more fragmented and uncoordinated and states will be unable to function under proposed Medicaid funding caps because they lack the ability to control costs for the largest portion of their budgets.

2. Pooled Medicare and Medicaid financing, managed care and capitated payment arrangements are essential tools, and with the appropriate protections and incentives, they can be harnessed to address many of the problems in the current system while preserving the basic rights and benefits to seniors.

3. States must be supported in their efforts to seek creative ways to pool Medicare and Medicaid financing and work with providers to develop delivery systems to integrate acute and long term care. Congress should encourage HCFA to allow more 1115/222 waiver demonstrations. Such programs allow rearrangement of fiscal and utilization incentives to provide for more cost effective services, administrative efficiency and to increase accountability for care outcomes.

4. "Catch 22" budget neutrality methodologies for these programs must be adjusted.

5. Far more investment must be made in measurement of outcomes for frail dual eligibles and for expansion of ombudsman and client education programs to assure credibility of managed care programs for dual eligibles.

6. Medicare and Medicaid policy makers within HCFA should implement a system wide approach to mitigating conflicts caused by enrollment of dual eligibles in Medicare managed care plans.

7. Policies under both Medicare and Medicaid should encourage new partnerships and new organizational structures capable of taking risk for an integrated package of acute and long term care services. Elimination of the 50/50 rule is one policy change that could encourage integrated delivery systems.

8. Reform of the AAPCC is essential to expanding and bringing more equity to health care coverage choices for seniors in rural areas. Many states will be unable to move forward with integrated models without these changes. In Minnesota changes in the formula are critical to bringing equity to our rural areas and expanding our integrated model.

A PERSONAL NOTE

I have worked with Medicare and Medicaid for the past 25 years as a county case worker, consumer advocate, state long term care ombudsman, rate setter, regulator and program developer. I have also helped guide a father with Alzheimers and various other relatives through a confusing array of services, paper work and payment arrangements. I no longer have much patience for the current system. When I look toward my own retirement I fear that time is growing too short to assure that the kind of integrated delivery systems that could be possible will be there. I hope we are not forced to wait until the demographic crisis eclipses us to develop the programs that could be more effective in addressing our problems. Thank you for this opportunity to bring these concerns to your attention.